INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

GRANT AWARD AGREEMENT
Fiscal Year 2019-20
Disability and Healthcare Insurance Fraud Program

The Insurance Commissioner of the State of California hereby makes award of funds to **Fresno County**, Office of the District Attorney, in the amount and for the purpose and duration set forth in this grant award.

This grant award consists of this agreement and the application for the grant which is made a part hereof. By acceptance of the grant award, the grant award recipient agrees to administer the grant project in accordance with all applicable statutes, regulations and Request-for-Applications (RFA).

Duration of Grant: The grant award is for the program period, **July 1, 2019** through **June 30, 2020**.

Purpose of Grant: This grant award is made pursuant to the provisions of California Insurance Code Section 1872.85 and shall be used solely for the purposes of enhanced investigation and prosecution of disability and healthcare insurance fraud cases.

Amount of Grant: The grant award agreed to herein is in the amount of **$183,653**. This amount has been determined by the Insurance Commissioner. However, the actual total award amount for the county is contingent on the collection and the authorization for expenditure pursuant to the Government Code Section 13000 et seq. The grant award shall be distributed pursuant to Section 1872.85 of the Insurance Code.

Official Authorized to Sign for Applicant/Grant Recipient Lisa Smittcamp Name: Lisa A. Smittcamp Title: District Attorney Address: 2220 Tulare Street, Suite 1000 Fresno, CA 93721 Date: 9/12/19	**RICARDO LARA** Insurance Commissioner George Mueller Name: **George Mueller** Title: Deputy Commissioner Date: 10/7/19

I hereby certify upon my own personal knowledge that budgeted funds are available for the period and purposes of this expenditure.

Crista Hill — 10/21/19

Crista Hill, Budget Officer, CDI — Date

CALIFORNIA DEPARTMENT OF INSURANCE
FRAUD DIVISION

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM

REQUEST FOR APPLICATION
FISCAL YEAR 2019-2020

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GRANT APPLICATION CHECKLIST and SEQUENCE
FISCAL YEAR 2019-2020

THE APPLICATION MUST INCLUDE THE FOLLOWING:

	YES	NO
1. **GRANT APPLICATION TRANSMITTAL (FORM 02)** completed and signed by the district attorney?	☒	☐
2. **PROGRAM CONTACT FORM (FORM 03)** completed?	☒	☐
3. Original or certified copy of the **BOARD RESOLUTION (FORM 04)** included? If NOT, the cover letter must indicate the submission date.	☐	☒
4. **TABLE OF CONTENTS**	☒	☐
5. The County Plan includes:		
a) **COUNTY PLAN QUALIFICATIONS (FORM 05)**	☒	☐
b) **STAFF QUALIFICATIONS (FORM 06(A))**	☒	☐
c) **ORGANIZATIONAL CHART (FORM 06(B))**	☒	☐
d) **PROGRAM REPORT (DAR OR FORM 07)**	☒	☐
e) **COUNTY PLAN PROBLEM STATEMENT (FORM 08)**	☒	☐
f) **COUNTY PLAN PROGRAM STRATEGY (FORM 09)**	☒	☐
6. Projected **BUDGET (FORMS 10-12)** included?	☒	☐
a) **LINE-ITEM TOTALS VERIFIED**?	☒	☐
b) **PROGRAM BUDGET TOTAL (FORM 12)** matches amount requested on FORM 02?	☒	☐
7. **EQUIPMENT LOG (FORM 13)** completed and signed?	☒	☐
8. **JOINT PLAN (Attachment A)** completed and signed?	☒	☐
9. **CONFIDENTIAL CASE DESCRIPTIONS (Attachment B)** Is all content readable? A partial narrative is not acceptable.	☒	☐
10. **ELECTRONIC VERSION** (CD/DVD) included?	☒	☐

GRANT APPLICATION TRANSMITTAL

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM

Grant Period: July 1, 2019 to June 30, 2020

Office of the District Attorney, County of FRESNO,
hereby makes application for funds under the Disability and Healthcare Insurance Fraud Program pursuant to Section 1872.85 of the California Insurance Code.

Contact: Jerry Stanley

Address: Office of the District Attorney

2220 Tulare Street, Suite 1000

Fresno, CA 93721

Telephone: (559) 600-4366

(1) New Funds Being Requested: $ 383,810

(2) Estimated Carryover Funds: $ 38,400

Traci Fritzler,
Assistant District Attorney
(3) *Program Director*

Stephen Rusconi,
Business Manager
(4) *Financial Officer*

(5) *District Attorney's Signature*

Name: Lisa A. Smittcamp

Title: District Attorney

County: Fresno

Address: 2220 Tulare Street, Suite 1000

Fresno, CA 93721

Telephone: (559) 600-3141

Date:

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM
PROGRAM CONTACT FORM
FISCAL YEAR 2019-2020

1. Provide contact information for the person with day-to-day operational responsibility for the program, who can be contacted for questions regarding the program.

   a. Name: Jerry Stanley

   b. Title: Chief of Financial Crimes

   c. Address: 2220 Tulare Street, Suite 1000

      Fresno, CA 93721

   d. E-mail address: JStanley@fresnocountyca.gov

   e. Telephone Number: (559) 600-4336 Fax Number: (559) 600-2144

2. Provide contact information for the District Attorney's Financial Officer.

   a. Name: Stephen Rusconi

   b. Title: Business Manager

   c. Address: 2220 Tulare Street, Suite 1000

      Fresno, CA 93721

   d. E-mail address: SRusconi@fresnocountyca.gov

   e. Telephone Number: (559) 600-4447 Fax Number: (559) 600-4100

3. Provide contact information for questions regarding data collection/reporting.

   a. Name: Jerry Stanley

   b. Title: Chief of Financial Crimes

   c. Address: 2220 Tulare Street, Suite 1000

      Fresno, CA 93721

   d. E-mail address: JStanley@fresnocountyca.gov

   e. Telephone Number: (559) 600-4366 Fax Number: (559) 600-2144

BOARD OF SUPERVISORS RESOLUTION
FISCAL YEAR 2019-2020

The Resolution from the Board of Supervisors authorizing Fresno County to enter into a Grant Award Agreement with the California Department of Insurance will be forwarded no later than December 31, 2019.

COUNTY PLAN: QUALIFICATIONS
FISCAL YEAR 2019-2020

QUESTIONS

Answer the following questions to describe your experience in investigating and prosecuting disability and healthcare insurance fraud cases during the last two (2) fiscal years as specified in the California Code of Regulations, Title 10, Section 2698.97.1.

1. What areas of your disability and healthcare insurance fraud operation were successful and why?
    - Detail your program's successes for the 2017-2018 and 2018-2019 fiscal years ONLY. Include information you believe made your program successful.

The Fresno County District Attorney's Office Disability and Healthcare Fraud Unit (hereinafter referred to as Fraud Unit) has received funds to prosecute Disability and Healthcare fraud since 2014.

Fiscal Year 2017-2018

Senior District Attorney Investigator Shelly Sweeton (hereinafter referred to as SDAI) was assigned to the Fraud Unit in November 2016. During Fiscal Year 2016-2017 she opened an investigation involving the owner of a lingerie company billing for the most expensive mastectomy products on every patient. The referral received stated that the provider was billing for silicone prosthesis that were in fact only foam or fiber-filled. The provider also billed for non-covered products including underwear and swimsuits. The estimated loss as a result of the fraud was between $200,000 and $300,000. SDAI Sweeton contacted several insurance companies requesting all billing from this lingerie company. After a review of the records received, a search warrant for the home and business of the owner was written and served on September 21, 2017. Thirty-six boxes of evidence were seized. During a review of the records it was discovered that the owner of the company was also billing her insurance company for prosthetics for herself, even though she does not have a medical need for these products. Three additional search warrants were served on two banks and a billing company on October 27, 2017. SDAI Sweeton remained the lead case agent when she left the Fraud Unit and took a position with the California Department of Insurance Central Valley Regional Office (hereinafter referred to as Fraud Division) in July 2017. This investigation continued into Fiscal Year 2017-2018.

During Fiscal Year 2017-2018, the investigation involving the owner of the lingerie continued. As discussed above, search warrants were served on her home, business, two banks, and a billing company. Because of the volume of records seized, the review has been time consuming. SDAI Sweeton has located and interviewed three companies in which the owner was doing business for custom prosthesis from 2014-2017. She is comparing these records to the billings for custom prosthesis during the same time frame. SDAI Okazaki (assigned to the Fraud Unit in January 2018 as will be discussed below) assisted with the interviews and review of the records. It is anticipated that the investigation will be completed during Fiscal Year 2018-2019.

An investigation which began in 2016 was closed in August 2017. The investigation revealed that the physician legitimately billed for treating a patient every day of the year. The patient was autistic, had seizures and needed constant therapy. The parents verified that the physician was present each day and were very satisfied with his services.

The FBI returned an investigation involving the physician billing for services while he was out of the country back to the Fraud Unit in January 2018. Additional follow-up is being conducted by SDAI Okazaki. The provider submitted 462 insurance claims to Anthem Blue Cross during a period of time when he was out of the country. Patients are being interviewed to determine if the exam was conducted with the physician present.

A pharmacy fraud case referred by Department of Healthcare Services (hereinafter referred to as DHCS) was filed during Fiscal Year 2016-17. It involved the forging of prescriptions by a patient. The assigned DA billed his time to the Fraud Unit budget. He has experience in healthcare fraud and has worked in the auto fraud and workers' compensation fraud units for the past eleven years. The Fraud Unit obtained a conviction against this patient.

An additional investigation involving a chiropractor billing for using unauthorized equipment was opened during Fiscal Year 2017-2018. The allegation was that the chiropractor was using a retrofitted jigsaw in lieu of a Pettibon Tendon Ligament Muscle Stimulator. There is no FDA approval for such a self-made device. Investigation revealed that the jigsaw resembles the Pettibon Stimulator and works in much the same way. It was determined that it would be more appropriate for the Department of Chiropractic Examiners to conduct an administrative investigation into the use of this retrofitted device. The Fraud Unit referred this investigation to them.

Fiscal Year 2018-2019

During Fiscal Year 2018-2019 the Fraud Unit filed criminal charges resulting from the investigation involving the owner of the lingerie company. Sixty-seven counts of billing fraud under PC 550(a)(5) were filed. The amount of billing fraud is well in excess of $100,000. The case is working its way through the court system with a pending status hearing in June.

The investigation returned from the FBI in which the physician was billing for services while he was out of the country was closed. This closure was due to evidentiary problems proving the elements of billing fraud.

Seven investigations have been opened in Fiscal Year 2018-2019. One of the investigations is a disability insurance fraud case. The policy holder's last employment date is the date prior to the disability starting date. The payroll representative did not sign the initial disability claim form-employer statement. The SDAI is setting up interviews and has received the insurance claims file.

Another investigation opened this fiscal year is an auto accident in which damages to the vehicle are minor but medical costs are excessively high. This case is being investigated with the assistance of members of the Central Valley Workers' Compensation Fraud Task Force due to there being a workers' compensation claim arising from the accident.

The Fraud Unit initiated another investigation in which the claimant misrepresented her medical information while she was applying for a short-term disability income coverage. In her application, she denied having ever been treated for back trouble/disorder, arthritis, bone or joint disorder. Prior medical records are inconsistent with this representation. These records show claimant consulted and received treatment for right shoulder pain, right rotator cuff syndrome, right wrist joint pain and right ulnar styloid fracture. This treatment occurred for almost four years leading up to her applying for disability insurance.

Another investigation involves a doctor allegedly overbilling CPT Code 94200 with reference to pulmonary function tests for asthmatics. The reporting party noticed that this CPT code was listed repeatedly for every patient seen. According to the paperwork, the reporting party feels any asthmatic patient on that list would most likely not undergo this pulmonary function test during their regular allergy visit.

The SDAI has recently been assigned an investigation involving a dentist who owns a Sleep Medicine business. SIU identified questionable sleep study claims. This SIU noted provider bills for unusually high-level office codes (99214, 99204) likely based on time spent with a patient rather than the appropriate coding standards. Based on claims data, research regarding the provider's credentials, and reviews from patients, the SIU has identified that it is highly unlikely that the provider is appropriately conducting sleep studies nor is the provider trained in medicine to read the alleged tests. The sleep study codes billed require detailed breathing, heart rate, and oxygen saturation levels. Internet reviews indicate that the sleep studies only have electrodes attached to the patient's head while sleeping. In addition, while a dentist can bill medical office visits, it is suspicious that these would be high-level office visits for the codes billed of 99204 and 99214. These codes are reserved for in-depth visits

where the illness or diagnosis is of moderate medical complexity, which sleep apnea is not. The Blue Shield of California Medical Director advised that this provider is practicing out of scope and should not, nor is he qualified to, make diagnoses of sleep apnea or treat the illness.

Another investigation recently opened centers around a detox provider. A review of the enrollment applications indicate this provider may have utilized a capping and kickback scheme to recruit members for treatment. The SDAI has met with an investigator from the Disability and Healthcare Fraud Unit in San Bernadino County as part of the investigation.

The final investigation initiated by the Fraud Unit in Fiscal Year 2018-2019 involves a radiology company. The company is suspected of double billing for exams. The investigation was initiated when a patient reviewed her Explanation of Benefits and noticed her medical insurance company was billed for two MRIs when only one had been done. The patient notified her insurance company of the discrepancy, and the insurance company performed an audit of bills received from this company. The results of the audit uncovered a suspicious billing total of $791,051.05.

2. Specify any unfunded contributions and support (i.e., financial, equipment, personnel, and technology) your county provided to the disability and healthcare insurance fraud program.

The Fresno County District Attorney's Office contributed unfunded supervisorial and accounting support to the Fraud Unit during Fiscal Year 2018-2019. A Chief Deputy District Attorney supervised the DDA assigned to the cases being reviewed and in court. A Bureau of Investigations Commander supervised the work performed by the SDAI.

A Senior Budget Analyst who maintains control of the grant monies and assists with the preparation of the budget was also provided at no cost to the Fraud Unit budget. The analyst also maintains a record of all monies spent on behalf of the program. Legal assistants who perform secretarial duties and capture the statistics for the Fraud Unit are provided at no cost.

3. Detail and explain the turnover or continuity of personnel assigned to your disability and healthcare insurance fraud program. Include any rotational policies your county may have.

As discussed above, the decision was made to use the 2016-2017 funding for a SDAI. SDAI Shelly Sweeton was assigned to the Fraud Unit in November 2016. She began her law enforcement career in 1988. She worked for the Grover Beach Police Department from 1988 to January 2001. She was an investigator for the Santa Barbara County District Attorney's Office from 2001 to August 2007.

After joining the Fresno County District Attorney's Office in 2007, Ms. Sweeton was assigned to the Sexual Assault Unit for 5 years, the Homicide Unit for 3 years and Auto Fraud for one year before coming to the Fraud Unit. SDAI Sweeton opened several significant investigations while assigned to the Fraud Unit.

On July 31, 2017, SDAI Sweeton took a position with the Fraud Division. SDAI Jesse Perez was immediately assigned to the Fraud Unit to replace Ms. Sweeton. SDAI Perez worked at the Fresno County Sheriff's Department for five years before joining the Fresno County District Attorney's Office in 2000. He worked in the Homicide, Sexual Assault, and Welfare Fraud Units before being assigned to the Fraud Unit on July 31, 2017.

SDAI Jesse Perez worked in the Fraud Unit until December 31, 2017 when he took a medical leave of absence. On January 1, 2018, SDAI Henry Okazaki was assigned as his replacement. SDAI Okazaki has been in law enforcement since 1998. He was a police officer with the Fresno Police Department until 2014, when he joined the Fresno County District Attorney's Office. He spent almost three years in the Welfare Fraud Unit, and worked on the Felony Trial Team and the Subpoena Services Unit as well.

In February 2019, SDAI Brandon Cooper was assigned to the Fraud Unit replacing SDAI Okazaki. SDAI Cooper has been in law enforcement since 2009. He was a police officer with the Lemoore Police Department, working various assignments until 2016 when he joined the Fresno County District Attorney's Office. He has previous experience investigating fraud for the Public Integrity Unit of the Fresno County District Attorney's Office.

The Fresno County District Attorney's Office is committed to maintaining consistent personnel in the Fraud Unit, which can be seen by the immediate reassignment of a SDAI to replace a vacancy. It is important to have continuity of personnel to work ongoing cases, create and maintain relationships with law enforcement and the Fraud Division, and to build the knowledge necessary to be successful.

4. List the governmental agencies you have worked with to develop potential disability and healthcare insurance fraud cases.

Federal Bureau of Investigation and United States Attorney's Office

In Fiscal Year 2015-2016, the Fraud Unit established a working relationship with the Federal Bureau of Investigation and the United States Attorney's Office. There are monthly meetings of the Healthcare Fraud Working Group at the Eastern District United States Attorney's Office. DHCS investigators and DDAs from the Workers' Compensation Fraud Unit also attend the working group. The working group serves networking and educational purposes. It allows the members to foster working relationships with federal law enforcement. The case discussion educates all members of the trends in healthcare fraud at the federal and local levels.

California Department of Healthcare Services

The Fraud Unit has developed a working relationship and case referral system with the investigator from DHCS. A provider fraud case recently filed involving a registered nurse and medical technician discussed above was referred by DHCS.

Fresno Police Department

In Fiscal Year 2014-2015, the Fraud Unit met with financial crimes detectives to discuss the grant and facilitate case referrals. Subsequently, the Fraud Unit received two referrals. The Fraud Unit has maintained contact with the Fresno PD financial crimes unit.

Kern County District Attorney's Office

The Fraud Unit coordinates resources with the Kern County District Attorney's Office Healthcare Fraud Unit. On the bigger investigations, it is more efficient for counties to assist each other in an effort to streamline investigations. The SDAI has assisted Kern County reviewing medical records seized from a search warrant.

5. Were any frozen assets distributed in the current reporting period? (Assets may have been frozen in previous years.) If yes, please describe. If no, state none.

None.

COUNTY PLAN: STAFFING
FISCAL YEAR 2019-2020

COUNTY OF FRESNO

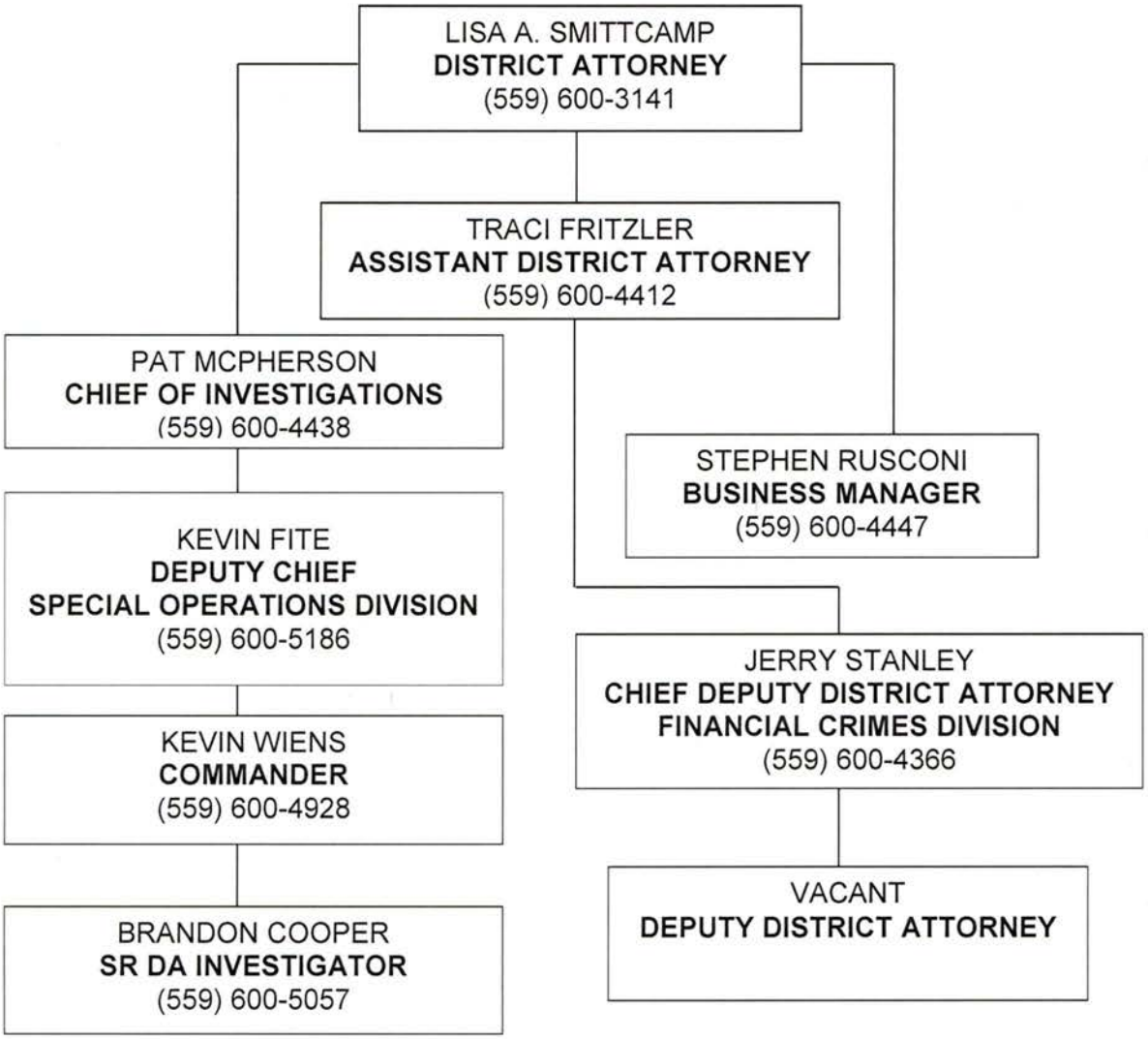
Prosecutors	% Time	Time With Program Start Date/End Date
None – when a case is filed the DDA bills his/her time to the Fraud Unit budget		

COUNTY OF FRESNO

Investigators	% Time	Time With Program Start Date/End Date
Shelly Sweeton	100%	11/1/16 – 07/31/17
Jesse Perez	100%	7/31/17 – 12/31/17
Henry Okazaki	100%	1/18/18 – 2/11/19
Brandon Cooper	100%	02/11/19 – present

COUNTY PLAN: ORGANIZATIONAL CHART
FISCAL YEAR 2019-2020

ORGANIZATIONAL CHART



COUNTY PLAN: DISTRICT ATTORNEY PROGRAM REPORT FISCAL YEAR 2018-2019

DAR (FORM 07) is submitted online

STATISTICAL INFORMATION WILL BE CAPTURED

FROM JULY 1, 2018 TO MAY 31, 2019

To access the DAR webpage on the CDI website, click on the following link or copy the URL into your browser.

http://www.insurance.ca.gov/0300-fraud/0100-fraud-division-overview/10-anti-fraud-prog/dareporting.cfm

COUNTY PLAN: PROBLEM STATEMENT
FISCAL YEAR 2019-2020

PROBLEM STATEMENT

Describe the types and magnitude of disability and healthcare insurance fraud (e.g., billing fraud, disability, embezzlement, identity theft, pharmacy, surgery center, unlawful solicitation) relative to the extent of the problem specific to your county.

Use local data or other evidence to support your description.

The current conditions in Fresno County create an environment in which disability and healthcare fraud can thrive. The drought, which has been present for several years, an uncertain economy, and unique population characteristics of Fresno County, make it a fertile environment for its consumers to become victims of disability and healthcare insurance fraud.

Fresno County is part of Central California's Farm Belt. Its economy is agriculturally focused. In 2012, Fresno County ranked number one in the nation in agricultural sales at $4.9 billion.[1] The effects of five consecutive years of drought are still being felt by the farming industry in Fresno County. In April 2016, the U.S. Bureau of Reclamation announced a five percent water allocation to Westside farmers.[2] As a result, approximately 200,000 acres of land were not farmed.[3] In 2014, at least 410,000 acres were lost to drought conditions leading to $800 million lost in farm revenues, and $447 million spent in additional pumping costs in the Central Valley.[4] It is estimated that the 2014 drought caused a statewide loss of $2.2 billion and 17,100 seasonal and part-time jobs.[1] This water shortage ultimately lost income for individual households.

The unemployment rate in Fresno County is higher than the national and state rates. In March 2017, the unemployment rate in Fresno County was 10.3% compared to the state unemployment rate of 4.9% and national rate of 5.1%. Although the

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[1] "2012 Census of Agriculture County Profile, Fresno County," U.S. Department of Agriculture National Agricultural Statistics Service (USDA-NASS)

[2] "Valley's Westside farmers seethe over tiny water allocation from feds," The Fresno Bee (April 1,2016, http://www.fresnobee.com/news/state/california/water-and-drought/article69443782.html (Accessed 5/11/16

[3] Ibid.

[4] "Economic Analysis of the 2014 Drought for California Agriculture," R. Howitt, J. Medellin-Azaura, D.MacEwan, J. Lund, D. Sumner, UC Davis Center for Watershed Sciences (July 2014), p.15

unemployment rate in Fresno County dropped slightly in January 2018, it is still over two percentage points higher than the national average.[2]

The combined factors of the extended drought and high unemployment contribute to an uncertain economic future for many Fresno County residents. This uncertainty will force some residents to take risks in order to make ends meet. Individuals filing a disability or healthcare claim may seize the opportunity to obtain more money and security through misrepresentations and fraud. Medical providers and industry professionals with a decreasing client base may turn to billing fraud to make ends meet.

Additionally, two population characteristics in Fresno County suggest that its citizens could be more susceptible to fraud than citizens of other counties: 1) approximately 43.7% of the population speaks a language other than English in the home and 2) the number of college educated adults over 25 with a bachelor's degree or higher is 19.5%, compared to the state average of 30.7%.[7]

These population characteristics play a role in billing fraud cases where fraud is committed by sophisticated professionals behind closed doors. It is difficult for law enforcement to detect this type of fraud without civilian assistance. Oftentimes, a consumer who reviews billing invoices and discovers the discrepancy discovers the fraud. With a large population who are not college educated and speak English as a second language, Fresno County is a jurisdiction where providers can take advantage. Believing their clientele are less likely to report or question fraudulent behavior, unscrupulous providers will commit billing fraud with a sense of impunity.

Provider and medical fraud schemes often originate in Southern California and make their way to Fresno County. In these cases, skillful fraudsters send accomplices to Fresno County to carry out their fraudulent schemes while remaining undetected in Southern California. Frequently, the injured people in these cases are Spanish speaking and unable to take an active role in their treatment or question billing practices.

Healthcare spending will continue to increase in the future. America's total health spending is approximately $2.7 trillion or 17% of Gross Domestic Product (GDP).[8]

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[5]Ibid, p. ii

[6]"Fresno Metropolitan Statistical Area (MSA), Fresno County," (April 15, 2016) State of California Employment Development Department **http://www.labormarketinfo.edd.ca.gov/file/lfmonth/frsn$pds.pdf** (Accessed 5/13/16)

[7] "State and County Quick Facts, Fresno County, California" (2009-2013) U.S. Census Bureau, **http://quickfacts.census.gov/qfd/states/06/06019.html** (Accessed 5/14/15)

[8]"The $272 Billion Swindle," The Economist (May 2014), **http://www.economist.com/news/united-states/21603078-why-thieves-love-americas-health-care-system-272-billion-swindle** (Accessed 5/1/15)

[9]"National Health Care Expenditure Projections 2014-2024," Centers for Medicare and Medicaid Services (2014), **https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html** (Accessed 5/16/16)

[10]"Eliminating Waste in US Health Care," DM. Berwick & AD Hackbarth. The Journal of the American Medical Association (April 11, 2012)

[11]"The Private Insurance Market in California 2013," California Health Care Foundation (February 2015), **http://www.chcf.org/publications/2015/02/data-viz-health-plans** (Accessed 5/14/15)

The Affordable Care Act has produced a significant impact on the expenses of health insurance. Private health insurance coverage is more prevalent than government coverage at 65.5% and 37.3% respectively. By 2024, it is estimated that healthcare spending will account for 19.6% of GDP.[9] The Affordable Care Act and the aging baby boomer population have led to an influx of capital into the healthcare industry. This increase in capital has attracted fraudsters and created incentives for medical industry professionals to commit insurance fraud. A 2012 study published in the Journal of the American Medicine Association (JAMA), estimated between $82 billion and $272 billion in 2011 was lost due to healthcare fraud or spent in law enforcement efforts to catch the fraudsters.[10] It is vital that local law enforcement agencies obtain the industry knowledge and professional connections necessary to prosecute healthcare insurance fraud effectively. Over half of Californians, close to 14 million, obtain healthcare coverage through private carriers in group or individual plans.[11]

By investigating and prosecuting fraud in the private health insurance realm, local law enforcement can ensure that the premiums paid by millions of Californians will be kept at fair and reasonable amounts.

COUNTY PLAN: PROGRAM STRATEGY
FISCAL YEAR 2019-2020

PROGRAM STRATEGY

1. Explain how your county plans to resolve the problem described in your problem statement. Include improvements in your program.

For Fiscal Year 2019-2020, the Fraud Unit is requesting funding for a full time SDAI and a half time DDA. The SDAI will spend the necessary time to investigate healthcare insurance fraud cases. As discussed above, there are seven open investigations. Once these investigations are completed, the DDA can prosecute the cases. During Fiscal Year 2018-2019 a DDA was not specifically assigned to the Fraud Unit. The provider fraud case involving the owner of a lingerie company fraudulently billing mastectomy products was filed by a DDA who billed his time to the Fraud Unit budget. Rather than have cases filed by different DDAs, it will provide more continuity to the program to have a dedicated DDA who can work with the SDAI during the investigation to develop a strategy for the case, and learn the nuances of healthcare fraud together.

The DDA and SDAI will continue to attend the monthly meetings of the Healthcare Fraud Working Group at the US Attorney's Office. The Fraud Unit can assist in joint healthcare investigations where appropriate. The SDAI assisted the FBI with their investigation discussed above by securing records from the insurance companies that were needed to prove the fraud. Once that portion of the investigation was completed, the case was turned over to the Fraud Unit for completion.

During Fiscal Year 2019-2020, the Fraud Unit will coordinate with Kern County who also has a Healthcare and Disability Fraud Program. Sharing resources will enhance each county's ability to finish investigations in a timely manner.

The Fraud Unit will also make efforts to meet individually with Healthcare SIUs. Building individual working relationships with SIU investigators will educate industry professionals on the type of cases the Fraud Unit investigates and prosecutes. This communication will increase suspected fraud case referrals to the Fraud Unit.

Healthcare provider fraud is unique and complex. The standard experienced criminal investigator or prosecuting attorney does not know healthcare industry terminology, procedures, and trade practices. It is a specialized area of criminal prosecution. The law enforcement connections and relationships made in this last fiscal year will be carried forward by the Fraud Unit. The SDAI and DDA will continue to work with CDI investigators to identify and develop cases from fraud referrals.

2. What are your plans to meet the announced goals of the Insurance Commissioner? A copy of the goals have been provided for your reference.

   - If these goals are not realistic for your county, please state why they are not, and what goals you can achieve. What is your strategic plan to accomplish the goals?

The Fraud Unit will meet the Insurance Commissioner's goals by having a full time investigator, who can devote needed resources to the investigation of medical provider fraud cases, which have the highest impact on the healthcare system. As discussed above, these investigations are labor intensive. With a half time DDA, the investigator and prosecutor can work together from the beginning of the investigation to develop the case.

The Fraud Unit will continue to coordinate with other agencies who are working to combat healthcare fraud in Fresno County. The Fraud Unit will meet with individual SIUs to build connections necessary for the successful referral, investigation, and prosecution of healthcare insurance fraud cases. The Fraud Unit will also continue its participation in the working group discussed above, as well as the Fraud Division SIU roundtables. It is important for the Fraud Unit to have a network of resources that can assist staff in identifying and investigating complex billing fraud schemes.

The Fraud Unit will conduct outreach meetings with healthcare professional organizations, including pharmacy associations, and local police agencies to discuss fraud trends. Through outreach with various medical professionals, the Fraud Unit will learn more about the industry and learn how to identify fraudulent conduct in specific practice areas.

3. What goals do you have that require more than a single year to accomplish?

The investigation and prosecution of medical provider fraud cases will take longer than one year to accomplish. These cases often require multiple search warrants for business records and forensic review of evidence seized. Some cases may require surveillance or an undercover operation. The Fraud Unit will work with the Fraud Division to find ways to streamline the larger investigations. Please see Attachment "A" for the Joint Plan. For example, the Fraud Unit will determine if search warrants are absolutely necessary to investigate a case or if the case can be investigated and proven by the use of governmental agency records and witnesses. If any case takes longer than one year to investigate, the Fraud Unit will move forward into the second year to follow the case to its conclusion.

4. Training and Outreach

   - List the **insurance fraud training received** by each county staff member in the disability and healthcare fraud unit **during Fiscal Years 2017-2018 and 2018-2019**.

In Fiscal Year 2017-2018 SDAI Jesse Perez attended the following training:

- CDAA Fraud Symposium

In Fiscal Year 2017-2018 SDAI Henry Okazaki attended the following training:

- April 2018: NICFIA Monterey

- Describe what kind of training/outreach **you provided in Fiscal Year 2018-2019** to local Special Investigative Units, as well as, public and private sectors to enhance the investigation and prosecution of disability and healthcare insurance fraud. Also describe any coordination with the Fraud Division, insurers, or other entities. Do not include presentation materials (e.g., fliers, power points, sign in sheets).

In Fiscal Year 2017-2018, the Fraud Unit established connections with local law enforcement to discuss the investigation of healthcare fraud. The SDAI regularly attends the monthly meetings of the Healthcare Fraud Working Group at the U.S. Attorney's Office. This group discusses ongoing trends, investigations, and coordinates investigative efforts. The SDAI also regularly attends bimonthly SIU meetings, which discusses healthcare fraud trends. The DDA that works with the SDAI also attends these meetings.

- Describe what kind of training/outreach **you plan to provide in Fiscal Year 2019-2020**.

In Fiscal Year 2019-2020, the Fraud Unit will focus on outreach to healthcare and insurance industries. The Fraud Unit will also conduct outreach with medical professionals and organizations. By conducting discussion groups with medical professionals, the Fraud Unit staff will learn upcoming trends and become familiar with standards and vocabulary specific to the medical industry. The Fraud Unit will seek to obtain similar information in other practice areas and utilize that information in the investigation and prosecution of healthcare insurance fraud.

Additionally, the Fraud Unit will form and build relationships with individual healthcare SIUs. These relationships will facilitate case referrals and strengthen the investigation of cases.

In its outreach efforts, the Fraud Unit will coordinate with the Fraud Division. The SDAI is housed at the Fraud Division with the detective who is also assigned to Healthcare and Disability Fraud. This allows for the sharing of expertise as well as the ability to assist with each other's investigations.

5. Describe the county's efforts and the district attorney's plan to obtain restitution and fines imposed by the court to the Disability and Healthcare Fraud Account.

The Fraud Unit's practice is to collect restitution prior to a plea whenever possible. The collection of restitution prior to plea ensures that restitution is paid to the victims. There is also the option to obtain a restitution order pursuant to Penal Code §1214 which allows victims to enforce the restitution order as a civil judgment if the defendant fails to pay full restitution during the term of probation.

The Fraud Unit maintains a database of all restitution orders on criminal convictions. Payments are made directly to our Unit, which we document and then forward to the

victim(s). If a payment is missed, staff immediately sends a notification letter to the defendant(s) reminding him/her of the obligation.

If the letter is unsuccessful staff contacts the Probation Department and the defendant's attorney and calendars a Probation Violation hearing.

6. Identify the performance objectives that the county would consider **attainable** and would have a significant impact in reducing disability and healthcare insurance fraud. Project a count you expect to **actively** investigate. Do not include cases that are open and assigned but have little or no expectation of being worked.

   Projection for FY 2019-2020:

   a. ___7___ new investigations will be opened and worked during FY 2019-2020

   b. ___3___ new prosecutions will be initiated during FY 2019-2020

   Prior year's projection from FY 2018-2019 submitted RFA:

   c. ___5___ new investigations will be initiated during FY 2018-2019

   d. ___3___ new prosecutions will be initiated during FY 2018-2019

7. If you are asking for an increase over the amount of grant funds awarded last fiscal year, please provide a brief description of how you plan to utilize the additional funds.

$ 383,810 FY 2019-2020 Grant REQUEST	$ 183,653 FY 2018-2019 Grant AWARD	$ 200,157 FY 2019-2020 Increase Requested

Utilization Plan:

The Fraud Unit will use the additional funds to assign a dedicated DDA who will devote fifty percent of his/her time to reviewing and prosecuting healthcare fraud cases.

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM
BUDGET: PERSONNEL SERVICES
FISCAL YEAR 2019-2020

COUNTY NAME: FRESNO

A. PERSONNEL SERVICES: Salaries and Employee Benefits		COST
(1) SENIOR DISTRICT ATTORNEY INVESTIGATOR:		
This individual devotes 100% of time to this program.		
Annual salary:	$100,736	$ 100,736
Benefits:		
Retirement: *($100,736 @ .9218)*		
OASDI: *($100,736 *.0765)*	$7,706	
Health Ins- Annual:	$11,641	
Unemployment-Annual:	$98	
Workers Comp-Annual:	$672	
Admin Fee- Annual:	$111	$ 113,086
(.5) DEPUTY DISTRICT ATTORNEY:		
This individual devotes 50% of time to this program.		
Annual salary: *($138,623 * 50%)*	$69,312	$ 69,312
Benefits:		
Retirement: *($69,312 @ .6480)*	$44,914	
OASDI: *($69,312 *.0765)*	$5,302	
Health Ins- Annual:	$5,755	
Unemployment-Annual:	$49	
Workers Comp-Annual:	$336	
Admin Fee- Annual:	$56	$ 56,412
SUMMARY:		
Salaries	$170,048	
Benefits	$169,498	
TOTAL	**$339,546**	
A. PERSONNEL SERVICES TOTAL		**$ 339,546**

FORM 11

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM
PROGRAM BUDGET: OPERATING EXPENSES
FISCAL YEAR 2019-2020

COUNTY NAME: FRESNO

B. OPERATING EXPENSES		COST
MOBILE COMMUNICATIONS: *24/7 radio network access ($87.50 per radio * 12 months)*	$	1,050
LIABILITY INSURANCE: *rates set by County Risk Management*	$	300
MAINTENANCE-EQUIPMENT: *repairs and maintenance of office equipment*	$	200
OFFICE EXPENSE: *routine office supplies*	$	2,000
DATA PROCESSING: *computer network access (connections, air cards, file storage), phone*	$	6,059
PROFESSIONAL & SPECIALIZED SERVICES: *costs may include records management,*	$	2,000
PUBLICATIONS: *costs for required attorney publication materials*	$	150
TRANSPORTATION, TRAVEL, & EDUCATION: *transportation, mileage, meals, and registration*	$	5,500
TRANSPORTATION & TRAVEL - FLEET: *program vehicle operation & maintenance costs*	$	10,000
INDIRECT COSTS: *(10% Salaries ($170,048)*	$	17,005
B. OPERATING EXPENSE TOTAL	**$**	**44,264**

FORM 12

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM PROGRAM BUDGET: EQUIPMENT FISCAL YEAR 2019-2020	
COUNTY NAME: FRESNO	
C. EQUIPMENT	*COST*
C. EQUIPMENT TOTAL	$ 0
D. PROGRAM BUDGET TOTAL	$ 383,810

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM
PROGRAM BUDGET: EQUIPMENT LOG
PRIOR FISCAL YEAR 2018-2019

COUNTY NAME: FRESNO

Equipment Ordered	Equipment Cost	Date Ordered	Date Received	Serial Number	Equipment Tag Number

Rows can be inserted as needed.

☒ **No equipment purchased.**

I certify this report is accurate and in accordance with the Grant guidelines.

Name: Jerry Stanley Title: Chief Deputy District Attorney

Signature: _____ Date: 6/7/19

Attachment "A"

Joint Investigative Plan

JOINT INVESTIGATIVE PLAN

I. STATEMENT OF GOALS

The purpose of the Joint Plan is to create a framework by which the Fresno County District Attorney's Office (hereinafter referred to as the Fraud Unit) and the CDI Central Valley Regional Office (hereinafter referred to as CDI) will effectively work together to combat Disability and Healthcare Fraud. Given the limited resources available, it is imperative not to duplicate efforts. It is also essential to use the resources of both agencies to their fullest potential. For example, if a case crosses county lines, the Fraud Unit will turn to CDI for assistance.

II. RECEIPT OF ASSIGNMENT OF CASE

CDI and the Fraud Unit will de-conflict upon assignment of investigations to ensure there is no duplication of investigative efforts. It is determined that CDI will conduct the investigation; the Fraud Unit will assign a prosecutor to the case to serve as a legal resource for CDI detectives. The assigned attorney and CDI detective will develop a litigation plan. This action is consistent with and supports the philosophy of vertical prosecution. They will work together to determine the charges to be filed and interviews to be conducted. During the initial meeting, timelines will be established for the completion of the investigation and priorities will also be set. The Fraud Unit will be apprised of all aspects of CDI's investigation.

III. INVESTIGATIONS

By working together at the outset of a case, and by sharing fraud referrals on a monthly basis, there will be no duplication of effort. Open communication will exist between both offices, which is the key to investigating the cases as expediently and efficiently as possible.

Vertical prosecution shall be used for all cases investigated. Vertical prosecution means the case detective from CDI or the Fraud Unit will communicate with the assigned prosecutor when the case is assigned for investigation. The assigned prosecutor and detective will meet in person or via telephone prior to starting the investigation. They will discuss the viability of the case, the investigative plan, and schedule meetings and case updates throughout the investigation.

a) Pursuant to the above provision, and to maximize the efficient and effective expenditure or resources, it is expected that each party will conduct its investigations independently in most cases. However, it is understood and agreed that either party will provide assistance to the other upon request in any investigation where such assistance is needed. This could include serving search warrants, interviewing witnesses, making arrests, etc.

b) Joint investigation may be undertaken in cases where the parties determine it is beneficial to combine resources to achieve the most efficient and effective result. This will be determined on a case-by-case basis. The Fraud

Division detective(s) and the assigned prosecutor shall communicate at regular intervals as necessary, but no less than one time a month, for the duration of a joint investigation and resulting prosecution.

c) It is the intent of this joint investigative plan to avoid duplication of investigative efforts by maintaining regular communication to discuss caseloads and share information concerning current investigations.

d) Ongoing investigations will be discussed at each meeting or more often as the matter dictates. A prosecutor will be assigned to each investigation to assist in any legal issues and to ensure that all elements of the case are present to meet charging requirements. This teamwork will reduce unnecessary investigative work and ensure that an investigation is terminated at the earliest possible time if it becomes apparent that no further amount of work would result in a prosecution.

e) The Chief of the Fraud Unit or his designee will be available to meet with the Fraud Division detective at any time to discuss any aspect of the case.

f) It is the intent of the parties that by maintaining regular communication and adhering to agreed upon plans and procedures, the completed investigation will result in the filing of criminal charges and a successful prosecution. At the same time, however it is understood that not every case that is investigated will result in prosecution. This can happen when the evidence does not develop as expected, material witnesses are no longer available, the case lacks jury appeal, the reasonable likelihood of conviction is minimal, or other unforeseen circumstances develop. The parties will take all possible steps to avoid such situations, as it is not desirable to expend investigative resources on cases that are not prosecuted in court.

g) When it becomes necessary, the Supervising Attorney or his designee will provide authorization to CDI to conduct surreptitious recordings pursuant to Penal Code 633.

The CDI Captain, or Captain's designee, and the Supervising Attorney will meet quarterly to discuss any issues or problems with the joint investigation of cases.

IV. UNDERCOVER OPERATIONS

In the event that an undercover operation occurs during this grant period, both the CDI Captain, or her designee and the Supervising Attorney will meet to develop a litigation plan which will identify the direction of the investigation, address relative investigative issues, define the responsibilities of both agencies and provide a method to resolve disagreements.

Either party may decide to conduct an undercover operation in a particular case using its own personnel and resources. In a situation where the Fraud Division conducts its own independent undercover investigation in Fresno County, the

detective will consult the assigned prosecutor on the case consistent with vertical prosecution.

In a case where there will be a "joint" undercover investigation, there will be a joint operational plan prepared prior to the start of the investigation, which outlines and specifies the goals and objectives of the investigation, as well as the duties and responsibilities, including personnel and financial responsibilities, of each of the parties in the investigation.

V. CASE FILING REQUIREMENTS

Cases presented to the Fraud Unit for filing will contain sufficient evidence to prove guilt beyond a reasonable doubt. This will include a verification that witnesses are available and willing to testify, and contain all available documentation needed to prove the fraud. Witnesses will be interviewed pursuant to Proposition 115 whenever feasible.

If interpreters were used, they will be identified and interviewed if possible. It is difficult to state a more definitive list of requirements for filing, since each case is different. Ongoing discussions between the detective and prosecutor shall notify the case detective as soon as practical if additional follow up investigation is warranted on the case. Every effort shall be made by the parties to complete the investigation as soon as practical.

The assigned prosecutor shall file criminal charges only if all of the following requirements are satisfied:

a) Based upon a complete investigation and a thorough consideration of all pertinent information readily available, the prosecutor is satisfied that the evidence shows the accused is guilty of the crime to be charged; and

b) There is sufficient legally admissible evidence of a corpus delicti; and

c) There is sufficient legally admissible evidence of the identity of the perpetrator of the crime; and

d) The prosecutor has considered the probability of a conviction by an objective fact-finder hearing the admissible evidence and has considered the evidence necessary to satisfy the legal proof of a criminal case; and

e) The admissible evidence is of such convincing force that it would warrant conviction of the crime charged by a reasonable and objective fact-finder after hearing all the evidence available at the time of charging and after hearing the most plausible, reasonable foreseeable defenses that could be raised under the evidence presented.

The Fraud Unit will provide CDI with a filing decision in writing within 30 days of the case submission. If after a complete review of the case the prosecutor decides not to file criminal charges, the prosecutor will contact and consult with the Fraud

Division to file criminal charges, the prosecutor will contact and consult with the Fraud Division to discuss the reasons for not filing the case. Both parties understand that not every case may result in criminal prosecution. A case may be declined for prosecution when the evidence does not develop as expected, material witnesses are no longer available, the reasonable likelihood of a conviction is minimal and the case lacks jury appeal or other unforeseen circumstances develop. The parties will attempt to avoid such situations, so as not to expend investigative resources on cases that will not result in a criminal prosecution. If a case has been formally submitted for filing and the prosecutor declines to prosecute, a formal rejection notice either in letter format or via e-mail outlining the reasons why the case is being declined will be sent to Central Valley Regional Office.

Certified Court Minute Orders on all Disability and Healthcare Fraud convictions/sentencings in Fresno County will be provided to CDI as soon as possible.

VI. TRAINING

CDI and the Fraud Unit will continue to work together to educate community on ways to combat fraud. Any requests for training received by CDI will be communicated to the Fraud Unit and vice versa. In this way both offices will conduct outreach together to employers, carriers and the public.

VII. PROBLEM SOLUTION

With CDI and the Fraud Unit working in a "team concept" it will be easier to resolve problems in an expedient manner. This will also reduce any potential breakdown in communications between offices.

In any event a conflict develops between investigators and prosecutors, using the open lines of communication established, the investigators and prosecutors will seek an early resolution. If a resolution cannot be achieved at this level, the immediate supervisors shall meet jointly with the investigators or prosecutors to seek resolution. It is anticipated that most, if not all, conflicts will be resolved by this step. If a conflict persists, then the Captain of CDI and the Supervisory Attorney for the Fraud Unit shall meet and confer.

VIII. OTHER

Both the CDI and the Fraud Unit will assist each other in the following ways"

1) Storing evidence.

2) Sharing specialized equipment.

3) The service of search warrants, arrest warrants, and/or subpoenas, and

2) Sharing specialized equipment.

3) The service of search warrants, arrest warrants, and/or subpoenas, and

4) In any other way necessary to accomplish our common goal of deterring Disability and Healthcare Fraud.

IX. CONCLUSION

The Fraud Unit and CDI agree to work together to investigate and prosecute Disability and Healthcare Fraud in Fresno County by working high impact cases. Both agencies agree that anti-fraud efforts must be conducted in a cost effective and efficient manner with professionalism and productivity being with the overriding principles governing the relationship. Both agencies further agree that the ultimate goal is to reduce healthcare fraud in Fresno County. In practical terms, both departments are currently undertaking the above procedures.

5/29/19

Jerry Stanley **Date**
Chief Deputy District Attorney
Fresno County District Attorney's Office

5/23/19

Christine Diep **Date**
Captain
California Department of Insurance-Fraud Division
Central Valley Regional Office